

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

Ventress

INSTITUTION

Wright, Richard

NAME

187140

NUMBER

R/S

Lay-in for _____ days from _____ to _____

(date)

due to _____

(date)

FOR PROFESSIONAL USE ONLY
CONFIDENTIAL RECORD
NOT TO BE PHOTOCOPIED

Instructions:

Report to Health Care
unit on 5-31-05 at 7:00 AM
for dental Appointment

Failure to follow the directions above may result in a disciplinary.

5/19/05

Date Issued

R. Thompson DA.

Signature



DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Wright, Richard # 187140
(Print Name) (Doc#)

acknowledge receipt of the following medical equipment or appliance:

- () Splint
() Eyeglasses
() Dentures
() Prothesis describe _____
() Wheelchair
() Cane
() Crutches
(☒) Other describe _____

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describe Insoles x2 for 6 months
8/18/05 - 2/18/06

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

X Richard V Wright
(Inmate)

8/18/05
(Date)

T. Stallcup
(Witness)

8-19-05
(Date)

INMATE NAME (LAST, FIRST, MIDDLE) <u>Wright, Richard</u>	DOC# <u>187140</u>	DOB <u>8/15/67</u>	R/S <u>Bm</u>	FAC. <u>VCF</u>
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DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Wright, Richard
(Print Name)

AIS # 187140
(Doc#)

acknowledge receipt of the following medical equipment or appliance:

() Splint

(X) Eyeglasses

() Dentures

() Prosthesis describe _____

() Wheelchair

() Cane

() Crutches

() Other describe _____

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I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Richard W. Wright 187140
(Inmate)

7-30-05
(Date)

G. Johnson (Witness)

7.30.05
(Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Wright, Richard	187140	8/15/67	B/m	VCF



DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Wright, Richard #187140
 (Print Name) (Doc#)

acknowledge receipt of the following medical equipment or appliance:

- () Splint
 () Eyeglasses
 () Dentures
 () Prothesis
 () Wheelchair
 () Cane
 () Crutches
 (☒) Other

* Benzoyl Peroxide - Apply
 once daily X 30 days
 describe 6/7/05 - 7/7/05

describe _____

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

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 (Inmate)

 (Date)

 (Witness)

 (Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Wright, Richard	187140	8/15/61	BM	VCF

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE

I, Richard Wright 187140 acknowledge receipt of the
(Inmate's Name, AIS #)
following medical equipment/appliance.

☒ Eyeglasses

☐ Dentures

☐ Prosthesis (please specify) _____

☐ Wheelchair

☐ Other (please specify) _____

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Richard W. Wright
(Inmate's Signature)

187140 13 Oct 96
(Date)

Linda C. Cook
(Witness' Signature)

10-13-96
(Date)

Distribution:

Original - Blue Medical Jacket

Yellow - Kilby Medical Supply

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RELEASE OF RESPONSIBILITY

Inmate's Name: Wright, Richard # 187140

Date of Birth: 8/15/87 Social Security No.: _____

Date: 6/29/05 Time: 7:30pm AM
P.M.

This is to certify that I, RICHARD WRIGHT, currently in
(Print Inmate's Name)

custody at the V.C.F., am refusing to
(Print Facility's Name)

accept the following treatment/recommendations: NO Show for Sick
(Specify in Detail)

Call.

**FOR PROFESSIONAL USE ONLY
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I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Refused to Sign William H
(Signature of Inmate)** (Signature of Medical Person)

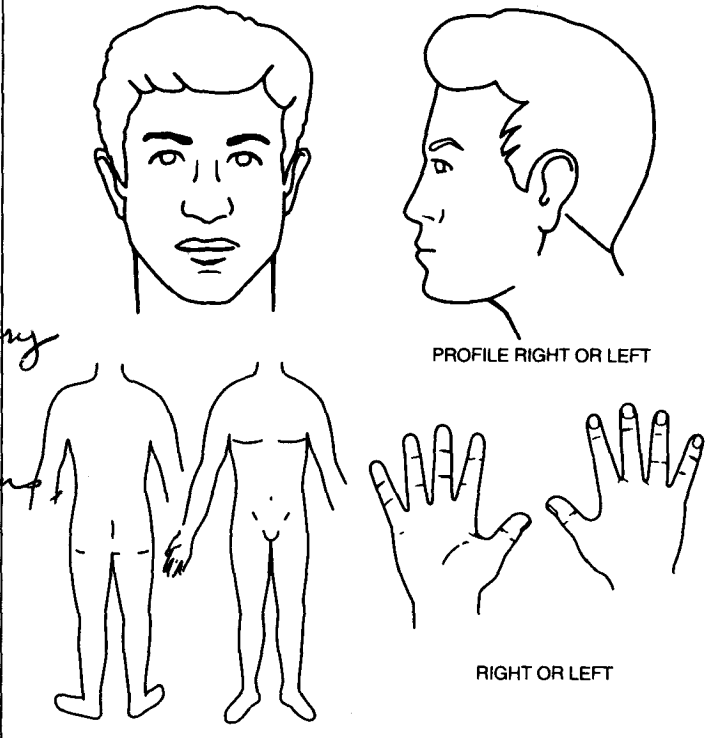
T. Stalls (pn) J. K. R.
(Witness) (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.



PRISON
HEALTH
SERVICES
INCORPORATED

EMERGENCY

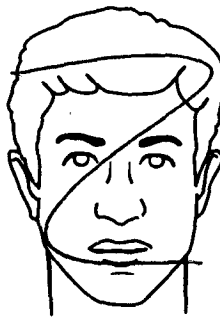
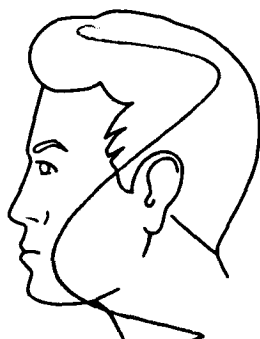
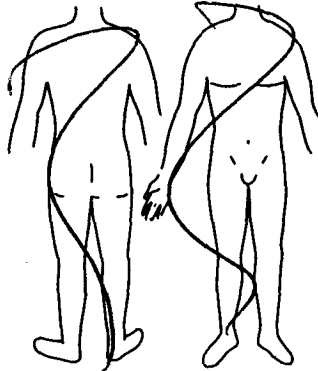
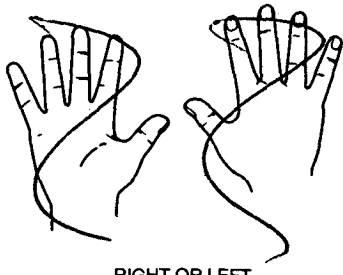
ADMISSION DATE 4/26/05		TIME 7:45 AM	ORIGINATING FACILITY Centres <input type="checkbox"/> SIR <input type="checkbox"/> PDL <input type="checkbox"/> ESCAPEE <input type="checkbox"/>		<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input type="checkbox"/> OUTPATIENT	
ALLERGIES NKDA		WT 176.25		CONDITION ON ADMISSION <input checked="" type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA		
VITAL SIGNS: TEMP 97.8		<input checked="" type="checkbox"/> ORAL <input type="checkbox"/> RECTAL	RESP. 20	PULSE 70	B/P 100/80	RECHECK IF SYSTOLIC <100> 50
NATURE OF INJURY OR ILLNESS S-DOC Body Chart				ABRASION /// CONTUSION # BURN ^{xx} / _{xx} FRACTURE ^Z / _Z LACERATION / SUTURES		
O-Awake et alert x3. Ambulatory C steady gait. Resp. even et unlabored. Skin warm et dry to touch. No abrasions				 PROFILE RIGHT OR LEFT RIGHT OR LEFT		
PHYSICAL EXAMINATION Injuries or lacerations noted to upper or lower extremities, chest, abd. or back area				ORDERS / MEDICATIONS / IV FLUIDS		
A-DOC Body Chart P-Release to DOC				TIME BY		
				FOR PROFESSIONAL USE ONLY		
				CONFIDENTIAL RECORD		
				NOT TO BE PHOTO COPIED		
DIAGNOSIS						
INSTRUCTIONS TO PATIENT						
DISCHARGE DATE 4/26/05		TIME 7:50 AM	RELEASE / TRANSFERRED TO <input checked="" type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE		CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE C. Hunter, LPN		DATE 4/26/05	PHYSICIAN'S SIGNATURE [Signature]		DATE	
INMATE NAME (LAST, FIRST, MIDDLE) Wright, Richard			DOC# 187140	DOB 8/15/67	R/S B/M	FAC. VCF



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INCORPORATED

EMERGENCY

Q2 sat - 97070

ADMISSION DATE 03 / 17 / 05		TIME 8:45 <u>AM</u>	ORIGINATING FACILITY <u>VCF</u>		<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input type="checkbox"/> OUTPATIENT	
ALLERGIES <u>Hylenol</u> <u>PPD</u>			CONDITION ON ADMISSION <input checked="" type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA			
VITAL SIGNS: TEMP <u>96.8</u>		<u>ORAL</u> RECTAL	RESP. <u>20</u>	PULSE <u>52</u>	B/P <u>130 / 90</u>	RECHECK IF SYSTOLIC <u>100</u> / <u>50</u>
NATURE OF INJURY OR ILLNESS S - "I need body chart b/c I'm getting put in lock up"			ABRASION /// CONTUSION # BURN <u>xx</u> <u>xx</u> FRACTURE <u>Z</u> <u>Z</u> LACERATION / <u> </u> SUTURES			
			  <p>PROFILE RIGHT OR LEFT</p>			
			  <p>RIGHT OR LEFT</p>			
PHYSICAL EXAMINATION D - B/m ambulated to HCU w/ DOC officer 5 difficulty. A/O x3. Resp. ease/unlabored NAD noted. Noted 0 cuts, bruises, edema, redness to ↑ & ↓ extremities. Denies any 40 pain or discomfort.			ORDERS / MEDICATIONS / IV FLUIDS TIME BY P - Release to DOC in satisfactory condition			
A - DOC Body Chart			FOR PROFESSIONAL USE ONLY CONFIDENTIAL RECORD NOT TO BE PHOTO COPIED			
INSTRUCTIONS TO PATIENT Sick call procedure explained						
DISCHARGE DATE 03 / 17 / 05		TIME 8:55 <u>AM</u>	RELEASE / TRANSFERRED TO <u>DOC</u>		CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE <u>A. Huie, RN</u>		DATE 3/17/05	PHYSICIAN'S SIGNATURE <u>R</u>		DATE	
INMATE NAME (LAST, FIRST, MIDDLE) Wright, Richard			DOC# 187140	DOB 8/15/67	R/S B/m	FAC. VCF